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Medicare: Payments to Physicians

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Jennifer O'Sullivan
Specialist in Social Legislation
Domestic Social Policy Division

Congressional Research Service

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Medicare: Payments to Physicians

Summary

Medicare law specifies a formula for calculating the annual update in payments for physicians' services. The formula resulted in an actual negative update in payments per service for 2002. Additional reductions were slated to go into effect again beginning in 2003; however, congressional action has prevented these reductions for 2003-2007. Many Members have been concerned about the impact of potential payment reductions on patients' access to services.

Medicare payments for services of physicians and certain nonphysician practitioners are made on the basis of a fee schedule. The fee schedule, in place since 1992, is intended to relate payments for a given service to the actual resources used in providing that service. Payments under the fee schedule are estimated at $62.8 billion in FY2007 (more than 14% of total benefit payments, including those made under the new prescription drug program). The fee schedule assigns relative values to services that reflect physician work (i.e., the time, skill, and intensity it takes to provide the service), practice expenses, and malpractice costs. The relative values are adjusted for geographic variations in costs. The adjusted relative values are then converted into a dollar payment amount by a conversion factor. The conversion factor for 2007 is $37.8975, the same level as in 2005 and 2006.

The fee schedule places a limit on payment per service but not on overall volume of services. The formula for calculating the annual update to the conversion factor responds to changes in volume. If the overall volume of services increases, the update is lower; if the overall volume is reduced, the update is higher. The intent of the formula is to place a restraint on overall increases in Medicare spending for physicians' services. Several factors enter into the calculation. These include (1) the Medicare economic index (MEI), which measures inflation in the inputs needed to produce physicians' services; (2) the sustainable growth rate (SGR), which is essentially a target for Medicare spending growth for physicians' services; and (3) an adjustment that modifies the update, which would otherwise be allowed by the MEI, to bring spending in line with the SGR target. The SGR target is not a limit on expenditures. Rather, the fee schedule update reflects the success or failure in meeting the target. If expenditures exceed the target, the update for a future year is reduced. This is what occurred for 2002. It was also slated to occur in subsequent years; however, legislation has prevented this from occurring through 2007. Congress has not, however, addressed the underlying issues related to application of the formula for the annual payment update.

The Tax Relief and Health Care Act of 2006 (P.L.109-432) freezes the 2007 conversion factor at the 2006 level. However, several other changes are incorporated in the 2007 fee schedule (including modifying the relative values for a number of services and changing the way practice expenses are calculated). As a result, payments for some services may decrease, while payments for other services may increase. This report will be updated as events warrant.

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Introduction: the Medicare Fee Schedule

Medicare is a nationwide program which offers health insurance protection for 43 million aged and disabled persons. Currently, 84% of beneficiaries obtain covered services through the "original Medicare" program (also referred to as "fee-for-service Medicare"). Under this program, beneficiaries obtain services through providers of their choice, and Medicare makes payments for each service rendered (i.e., fee-for-service) or for each episode of care. Approximately 16% of beneficiaries are enrolled in managed care organizations, under the Medicare Advantage program (formerly known as the Medicare+Choice program). These entities assume the risk for providing all covered services in return for a fixed monthly per capita payment.

Medicare law and regulations contain very detailed rules governing payments to physicians and other providers under the fee-for-service system. Payments for physicians' services under fee-for-service Medicare are made on the basis of a fee schedule. The fee schedule also applies to services provided by certain nonphysician practitioners such as physician assistants and nurse practitioners as well as the limited number of Medicare-covered services provided by limited licensed practitioners (chiropractors, podiatrists, and optometrists). Payments under the fee schedule are estimated at $60.3 billion in FY2006 and $62.8 billion in FY2007. (The FY2007 amount represents 14.2% of total Medicare benefits.)[1]

The law specifies a formula for the annual update to the physician fee schedule. Part of this update is based on whether spending in a prior year has exceeded or fallen below a spending target. The target (known as the sustainable growth rate (SGR)) is essentially a cumulative target for Medicare spending growth over time. If spending is in excess of the target, the update for a future year is reduced; the goal is to bring spending back in line with the target. Application of the update formula would have led to a negative update for each year beginning in 2002. The update for 2002 was a *negative* 5.4%. However, Congress overrode the application of the formula for 2003, 2004, and 2005; each of these years saw a slight increase. The Deficit Reduction Act of 2005 (DRA, P.L. 109-171, enacted February 8, 2006) froze the 2006 conversion factor at the 2005 level. The Tax Relief and Health Care Act of 2006 (P.L.109-432, enacted December 20, 2006) freezes the 2007 conversion factor at the same level for an additional year. Further, beginning July 1, 2007, physicians who voluntarily report certain quality measures could receive bonus payments of 1.5%.

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[1] Congressional Budget Office, March 2006 baseline. Note that these figures do not include spending by managed care plans for physicians' services; such plans are paid on a capitated basis for all services provided to Medicare beneficiaries.

Why the Fee Schedule Was Enacted

The fee schedule, established by the Omnibus Budget Reconciliation Act of 1989 (OBRA 1989, P.L. 101-239), went into effect January 1, 1992. The physician fee schedule replaced the reasonable charge payment method which, with minor changes, had been in place since the implementation of Medicare in 1966. Observers of the reasonable charge system cited a number of concerns including the rapid rise in program payments and the fact that payments frequently did not reflect the resources used. They noted the wide variations in fees by geographic region; they also noted that physicians in different specialties could receive different payments for the same service. The reasonable charge system was also criticized for the fact that while a high price might initially be justified for a new procedure, prices did not decline over time even when the procedure became part of the usual pattern of care. Further, it was suggested that differentials between recognized charges for physicians visits and other primary care services versus those for procedural and other technical services were in excess of those justified by the overall resources used.

The fee schedule was intended to respond to these concerns by beginning to relate payments for a given service to the actual resources used in providing that service. The design of the fee schedule reflected many of the recommendations made by the Physician Payment Review Commission (PPRC), a congressionally established advisory body. The PPRC was replaced by the Medicare Payment Advisory Commission (MedPAC) on September 30, 1997; it is responsible for advising the Congress on the full range of Medicare payment issues.

Calculation of the Fee Schedule

The fee schedule has three components: the *relative value* for the service; a *geographic adjustment*, and a national dollar *conversion factor*.

Relative Value. The relative value for a service compares the relative physician work involved in performing one service with the work involved in providing other physicians' services. It also reflects average practice expenses and malpractice expenses associated with the particular service. Each of the approximately 7,500 physician service codes is assigned its own relative value. The scale used to compare the value of one service with another is known as a resource-based relative value scale (RBRVS).

The relative value for each service is the sum of three components:

- *Physician work component*, which measures physician time, skill, and intensity in providing a service;
- *Practice expense component*, which measures average practice expenses such as office rents and employee wages (which, for certain services can vary depending on whether the service is

performed in a facility, such as an ambulatory surgical facility, or in a non-facility setting[2]); and
- *Malpractice expense component*, which reflects average insurance costs.

Geographic Adjustment. The geographic adjustment is designed to account for variations in the costs of practicing medicine. A separate geographic adjustment is made for each of the three components of the relative value unit, namely a work adjustment, a practice expense adjustment, and a malpractice adjustment.[3] These are added together to produce an indexed relative value unit for the service for the locality.[4] There are 89 service localities nationwide.

Conversion Factor. The conversion factor is a dollar figure that converts the geographically adjusted relative value for a service into a dollar payment amount. The conversion factor is updated each year.[5]

The 2007 conversion factor is $37.8975. Thus, the payment for a service with an adjusted relative value of 2.3 is $87.16.[6] Anesthesiologists are paid under a separate fee schedule, which uses base and time units; a separate conversion factor ($17.7594 in 2007) applies.

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[2] The lower facility-based payment reflects the fact that the facility itself receives a separate payment for its costs of providing the service, while the non-facility-based payment to the physician encompasses all practice costs.

[3] The geographic adjustments are indexes that reflect cost differences among areas compared to the national average in a "market basket" of goods. The work adjustment is based on a sample of median hourly earnings of workers in six professional specialty occupation categories. The practice expense adjustment is based on employee wages, office rents, medical equipment and supplies, and other miscellaneous expenses. The malpractice adjustment reflects malpractice insurance costs. The law specifies that the practice expense and malpractice indices reflect the full relative differences. However, the work index must reflect only *one-quarter* of the difference. Using only one-quarter of the difference generally means that rural and small urban areas receive higher payments and large urban areas lower payments than if the full difference were used. A value of 1.00 represents an average across all areas. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA, P.L. 108-173) placed a floor of 1.00 on the work adjustment for the 2004-2006 period; the Tax Relief and Health Care Act of 2006 (P.L.109-432) extends the provision through 2007. Areas that would otherwise have a value below 1.0 (primarily rural areas) receive higher payments over the period.

[4] For a detailed description of how the geographic adjustments are calculated, see Appendix B.

[5] Initially there was one conversion factor. By 1997, there were three factors: one for surgical services; one for primary care services; and one for all other services. The Balanced Budget Act of 1997 (BBA 97, P.L. 105-33) provided for the use of a single conversion factor beginning in 1998.

[6] The law requires that changes to the relative value units under the fee schedule can not cause expenditures to increase or decrease by more than $20 million from the amount of expenditures that would have otherwise been made. This "budget neutrality" requirement has been implemented through an adjustment to the conversion factor; however, in 2007 it is implemented through adjustment in relative values.

Bonus Payments. The law specifies that physicians who provide covered services in any rural or urban health professional shortage area (HPSA) are entitled to an incentive payment. This is a 10% bonus over the amount which would otherwise be paid under the fee schedule. The bonus is paid only if the services are actually provided in the HPSA, as designated under the Public Health Service Act. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) required the Secretary to pay automatically the bonus for services furnished in full county primary care geographic area HPSAs rather than having the physician identify that the services were furnished in such area.

MMA also provided for an additional 5% in payments for certain physicians in scarcity areas for the period January 1, 2005 through December 31, 2007. The Secretary is required to calculate, separately for practicing primary care physicians and specialists, the ratios of such physicians to Medicare beneficiaries in the county, rank each county (or equivalent area) according to its ratio for primary care and specialists separately, and then identify those scarcity areas with the lowest ratios which collectively represent 20% of the total Medicare beneficiary population in those areas. The list of counties will be revised no less often than once every three years unless there are no new data. There will be no administrative or judicial review of the designation of the county or area as a scarcity area, the designation of an individual physician's specialty, or the assignment of a postal zip code to the county or other area.

The listing of counties appears in Appendix I and Appendix J of the 2005 physician fee schedule update.[7]

Publication of Fee Schedule. Medicare is administered by the Centers for Medicare and Medicaid Services (CMS).[8] Each fall, CMS publishes in the *Federal Register* the relative values and conversion factor that will apply for the following calendar year. Updates to the geographic adjustment are published at least every three years. The fee schedule is generally published by November 1 and is effective January 1.

2006 Fee Schedule and DRA Changes. The final fee schedule for 2006 was issued November 21, 2005.[9] The published fee schedule provided for a reduction in the 2006 conversion factor. However, the DRA (enacted February 8,

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[7] U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, Medicare Program; Revision to Payment Policies Under the Physician Fee Schedule Update for Calendar Year 2005; Final Rule, 69 *Federal Register* 66235, Nov. 15, 2004.

[8] Prior to June 14, 2001, this agency was known as the Health Care Financing Administration (HCFA).

[9] U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, Medicare Program; Revision to Payment Policies Under the Physician Fee Schedule Update for Calendar Year 2006 and Certain Provisions Related to the Competitive Acquisition Program of Outpatient Drugs and Biologicals Under Part B; Final Rule, 70 *Federal Register* 70116, Nov. 21, 2005.

2006) froze the 2006 conversion factor at the 2005 level, effective January 1, 2006. CMS issued a fact sheet on February 10, 2006, announcing how this change would be implemented.[10] Specifically, Medicare contractors (the entities processing Medicare claims) were expected to begin paying at the higher rates within two days of the law's enactment. Further, claims that had already been processed would be reprocessed. Given the volume of claims involved, CMS anticipated that the reprocessing would not be completed until July 1, 2006. Physicians and other practitioners paid under the fee schedule could expect several aggregated (rather than claim-by-claim) payments during the period.

2007 Fee Schedule. The final fee schedule for 2007 was announced November 1, 2006, and published in the Federal Register on December 1, 2006.[11] With the exception of the conversion factor, other changes incorporated in the regulation remain in place for 2007. This includes changes in relative values and the phase-in of a new methodology for calculating practice expenses.

The published regulation assumed the conversion factor would be cut by 5%, as required by the statutory formula. However, as noted, the Tax Relief and Health Care Act of 2006 (P.L.109-432) freezes the 2007 conversion factor at the 2006 level. On December 22, 2006, two days after enactment, CMS announced that it had already notified the contractors who process the claims; it anticipated that they would be able to process the 2007 claims on a timely basis and that no reprocessing of claims would be needed.

P.L.109-432 also provides that, beginning July 1, 2007, physicians who voluntarily report certain quality measures can receive bonus payments of 1.5%. The specific implementation requirements are expected to be announced at a future date.

Beneficiary Protections

Medicare pays 80% of the fee schedule amount for physicians' services after beneficiaries have met the annual Part B deductible ($131 in 2007). Beneficiaries are responsible for the remaining 20%, known as coinsurance. A physician may choose whether to accept **assignment** on a claim.[12] In the case of an assigned claim, Medicare pays the physician 80% of the approved amount. The physician can only bill the beneficiary the 20% coinsurance plus any unmet deductible.

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[10] CMS, *Payment Provisions in the Original Medicare Program Immediately Affected by the Deficit Reduction Act*, Fact Sheet, Feb. 10, 2006, at [http://www.cms.hhs.gov/apps/media/press/release.asp?Counter=1779].

[11] U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, Medicare Program; Revision to Payment Policies Under the Physician Fee Schedule, etc; Final Rule, 71 *Federal Register* 69624, Dec. 1, 2006.

[12] Nonphysician practitioners (such as nurse practitioners and physician assistants) paid under the fee schedule are required to accept assignment on all claims. These practitioners are different from limited licensed practitioners (such as podiatrists and chiropractors), who have the option of whether to accept assignment.

When a physician agrees to accept assignment on *all* Medicare claims in a given year, the physician is referred to as a **participating physician**. Physicians who do *not* agree to accept assignment on *all* Medicare claims in a given year are referred to as **nonparticipating physicians**. It should be noted that the term "nonparticipating physician" does not mean that the physician doesn't deal with Medicare. Nonparticipating physicians can still treat Medicare patients and receive Medicare payments for providing covered services.

There are a number of incentives for physicians to participate, chief of which is that the fee schedule payment amount for nonparticipating physicians is only 95% of the recognized amount for participating physicians, regardless of whether they accept assignment for the particular service or not.

Nonparticipating physicians may charge beneficiaries more than the fee schedule amount on nonassigned claims; these **balance billing** charges are subject to certain limits. The limit is 115% of the fee schedule amount for nonparticipating physicians (which is only 9.25% higher than the amount recognized for participating physicians, i.e., 115% x .95 = 1.0925). (See **Table 1.)**

In 2005, 92% of physicians (and limited licensed practitioners) billing Medicare were participating physicians. Approximately 99% of Medicare-allowed charges for physicians' services were assigned in 2004.[13]

[13] MedPAC, *Medicare Payment Policy*, Report to the Congress, Mar. 2006. (Hereafter cited as MedPAC, Mar. 2006.)

Table 1. Medicare and Physicians

Type of physician and claim	Medicare pays	Beneficiary pays	Balance billing charges
Participating physician — Must take ALL claims on assignment during the calendar year. (Signs a participation agreement)	80% of fee schedule amount	20% of fee schedule amount (plus any unmet deductible)	None permitted
Nonparticipating physician — May take or not take assignment on a claim-by-claim basis			
(A) Takes **assignment** on a claim	80% of fee schedule amount (recognized fee schedule amount = 95% of recognized amount for participating physicians)	20% of fee schedule amount recognized for nonparticipating physicians (plus any unmet deductible)	None permitted
(B) Does not take assignment on a claim	80% of fee schedule amount (recognized fee schedule amount = 95% of recognized amount for participating physicians)	(a) 20% of fee schedule amount recognized for nonparticipating physicians (plus any unmet deductible); plus (b) any balance billing charges.	Total bill cannot exceed 115% of recognized fee schedule amount (actually 109.25% of amount recognized for participating physicians, i.e., 115% x 95%)

Participation Agreements

Physicians who wish to become participating physicians are generally required to sign a participation agreement prior to January 1 of the year involved. The agreement is automatically renewed each year unless the physician notifies the Medicare carrier that he or she wishes to terminate the agreement for the forthcoming year.

Submission of Claims

Physicians and practitioners are required to submit all claims for *covered* services to Medicare carriers. These claims must be submitted within one year of the service date. An exception is permitted if a beneficiary requests that the claim not

be submitted. This situation is most likely to occur when a beneficiary does not want to disclose sensitive information (for example, treatment for mental illness or AIDS). In these cases, the physician may not bill more than the limiting charge. The beneficiary is fully liable for the bill. If the beneficiary subsequently requests that the claim be submitted to Medicare, the physician must comply. Such exceptions should occur in only a very limited number of cases.

A physician or practitioner may furnish a service that Medicare may cover under some circumstances but which the physician or practitioner anticipates would not be covered in the particular case (for example, multiple nursing home visits). In this case, the physician or practitioner should give the beneficiary an *"Advance Beneficiary Notice" (ABN)* that the service may not be covered. If the claim is subsequently denied by Medicare, there are no limits on what may be charged for the service. If, however, the physician or practitioner does not give the beneficiary an ABN, and the claim is denied because the service does not meet coverage criteria, the physician cannot bill the patient. (See **Table 2.**)

Table 2. Billing Provisions Applicable to Claims Denied by Medicare

Claim submission to Medicare	Claim denied	Billing limits on denied claim
Claim submitted without advance beneficiary notice (ABN) Physician submits claim according to billing rules for assigned or unassigned claims, as appropriate.	(A) Denied because the service is categorically not covered (e.g., hearing aids)	No limits on amounts physician can charge.
	(B) Denied because service does not meet coverage criteria.	Physician cannot bill beneficiary and must refund any amounts beneficiary may have paid.[a]
Claim submitted with advance beneficiary notice (ABN) Physician submits claim according to billing rules for assigned or unassigned claims, as appropriate.	(A) Denied because the service is categorically not covered. (e.g., hearing aids)	No limits on amounts physician can charge.
	(B) Denied because service does not meet coverage criteria.	No limits on amounts physician can charge.

a. If Medicare pays under a "waiver of liability" because the physician had no reason to know claim would not be paid, regular billing rules apply.

There is another condition under which physicians and practitioners do not submit claims for services which would otherwise be covered by Medicare. This occurs if the physician or practitioner is under a private contacting arrangement (see discussion under Appendix D). In this case, physicians are precluded from billing Medicare or receiving any payment from Medicare for two years.

Refinements in Relative Value Units

On average, the work component represents 52.5% of a service's relative value, the practice expense component represents 43.6%, and the malpractice component represents 3.9%.[14] The law provides for refinements in relative value units.

The work relative value units incorporated in the initial fee schedule were developed after extensive input from the physician community. Refinements in existing values and establishment of values for new services have been included in the annual fee schedule updates. This refinement and update process is based in part on recommendations made by the American Medical Association's Specialty Society Relative Value Update Committee (RUC) which receives input from 100 specialty societies. The law requires a review every five years. The 1997 fee schedule update reflected the results of the first five-year review. The 2002 fee schedule reflected the results of the second five-year review. The 2007 fee schedule reflects the results of the third five-year review,

While the calculation of work relative value units has always been based on resources used in providing a service, the values for the practice expense components and malpractice expense components were initially based on historical charges. The Social Security Amendments of 1994 (P.L. 103-432) required the Secretary to develop a methodology for a resource-based system for practice expenses which would be implemented in 1998. Subsequently, the Secretary developed a system. The Balanced Budget Act of 1997 (BBA 97, P.L. 105-33) delayed its implementation. It provided for a limited adjustment in practice expense values for certain services in 1998. It further provided for implementation of a new resource-based methodology to be phased-in beginning in 1999. The system was fully phased in by 2002. The 2007 fee schedule adopts a new methodology for determining practice expenses; this change is to be phased-in over four years. (See *Appendix C*.)

BBA 97 also directed HCFA (now CMS) to develop and implement a resource-based methodology for the malpractice expense component. HCFA developed the methodology based on malpractice premium data. Malpractice premiums were used because they represent actual expenses to physicians and are widely available. The system was incorporated into the fee schedule beginning in 2000.

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[14] MedPAC, Mar. 2006.

Calculation of Annual Update to the Fee Schedule

As noted, the conversion factor is a dollar figure that converts the geographically adjusted relative value for a service into a dollar payment amount. The conversion factor is the same for all services. It is updated each year according to a complicated formula specified in law. The intent of the formula is to place a restraint on overall spending for physicians' services. Several factors enter into the calculation of the formula. These include (1) the sustainable growth rate (SGR) which is essentially a cumulative target for Medicare spending growth over time (with 1996 serving as the base period); (2) the Medicare economic index (MEI) which measures inflation in the inputs needed to produce physicians' services; and (3) the performance adjustment factor which modifies the update, which would otherwise be allowed by the MEI, to bring spending in line with the SGR target.

The SGR system was established because of the concern that the fee schedule itself would not adequately constrain increases in spending for physicians' services. While the fee schedule specifies a limit on payments per service, it does not place a limit on the volume or mix of services. The use of the SGR is intended to serve as a restraint on aggregate spending. The SGR targets are not limits on expenditures. Rather the SGR represents a glidepath for desired cumulative spending from April 1996 forward. The fee schedule update reflects the success or failure in meeting the goal. If spending over the period is above the cumulative spending target for the period, the update for a future year is reduced. If expenditures are less than the target, the update is increased. If expenditures equal the target, the update would equal the change in the MEI.

General Rules

The annual percentage update to the conversion factor, equals the MEI, subject to an adjustment (known as the performance adjustment) to match target spending for physicians' services established under the SGR system.[15]

Sustainable Growth Rate. The law specifies a formula for calculating the SGR. It is based on changes in four factors: (1) estimated changes in fees; (2) estimated change in the average number of Part B enrollees (excluding Medicare Advantage beneficiaries); (3) estimated projected growth in real gross domestic product (GDP) growth per capita; and (4) estimated change in expenditures due to changes in law or regulations. In order to even out large fluctuations, MMA changed the GDP calculation from an annual change to an annual average change over the preceding 10 years (a "10-year rolling average").

Performance Adjustment Factor. The performance adjustment sets the conversion factor at a level so that projected spending for the year will meet allowed spending by the end of the year. Allowed spending for the year is calculated using the SGR.

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[15] During a transition period (2001-2005), an additional adjustment was made to achieve budget neutrality. The adjustment was -0.2% for the first four years and + 0.8% in the last year.

The technical calculation of the adjustment factor has changed several times. Since 2001, the adjustment factor has been the sum of: (1) the *prior year adjustment component*, and (2) the *cumulative adjustment component*.[16] Use of both the prior year adjustment component and the cumulative adjustment component allows any deviation between cumulative actual expenditures and cumulative allowed expenditures to be corrected over several years rather than a single year.

In no case can the adjustment factor be less than minus 7% or more than plus 3%. Thus, despite calculations which would have led to larger reductions, the formula adjustment has been minus 7% for the last several years. However, Congress overrode the formula calculation for 2003-2006.

Recent Updates

Calculation for 2002. On November 1, 2001, CMS announced the conversion factor update for 2002. The update was actually negative: -5.4% (compared to a 4.5% increase in 2001). Thus, the conversion factor for 2002 ($36.1992) was 5.4% less than the conversion factor for 2001 ($38.2581).

Calculation For 2003. The law requires the fee schedule for the following year to be issued by November 1. However, due to technical complications, publication of the 2003 fee schedule was first delayed until December 31, 2002 and revised on February 28, 2003 in response to the enactment of the Consolidated Appropriations Resolution of 2003 (CAR). As a result of the delays, the 2003 fee schedule was effective March 1, 2003. The December regulation would have set the 2003 update at a *negative* 4.4%. As a result of the CAR provision, the update for 2003 was 1.6%.

Calculation for 2004. In March 2003, CMS estimated that the 2004 update to the conversion factor would be a *negative 4.2%*. The primary factor contributing to the negative update was that spending for physicians' services in 2002 increased faster than the target and was expected to stay above the target through 2003. Therefore the update for 2004 would need to be lowered to place cumulative spending in line with the target. On November 7, 2003, CMS issued its final fee schedule regulation, which set the update at a *negative* 4.5%, an even larger reduction than had been contemplated earlier in the year.

Enactment of MMA superceded the update specified in the November 2003 regulation. It specified that the update for 2004 and 2005 could not be less than 1.5%. On January 7, 2004, CMS issued revised regulations which reflected a number

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[16] The prior year adjustment component is determined by (1) computing the difference between allowed expenditures for physicians' services for the prior year and the amount of actual expenditures for that year; (2) dividing this amount by the actual expenditures for that year; and (3) multiplying that amount by 0.75. The cumulative adjustment component is determined by (1) computing the difference between allowed expenditures for physicians' services from Apr. 1, 1996 through the end of the prior year and the amount of actual expenditures during such period; (2) dividing that difference by actual expenditures for the prior year as increased by the SGR for the year for which the performance adjustment factor is to be determined; and (3) multiplying that amount by 0.33.

of MMA provisions. It set the update at 1.5%. Thus, the conversion factor for 2004 was set at $37.3374.

Calculation for 2005. On November 15, 2004, CMS announced that the fee schedule update would be 1.5%, the minimum allowed by the MMA provision. The 2005 conversion factor was set at $37.8975. In the absence of the MMA provision, the update would have been a *negative* 3.3%.

Calculation for 2006. The final physician fee schedule, published on November 21, 2005, provided for a *negative* 4.4% update. (This was based on an estimated 2.8% MEI increase and a minus 7% performance adjustment.) Thus the 2006 conversion factor would have been $36.1770,[17] less than that in effect in 2000. However, DRA froze the 2006 conversion factor at the 2005 level.

Calculation for 2007. The 2007 physician fee schedule, which was announced on November 1, 2006 (and published in the *Federal Register* on December 1, 2006), provided for a 5% reduction in the conversion factor from the 2006 level. However, the Tax Relief and Health Care Act of 2006 (P.L.109-432), enacted December 20, 2006, provides that the 2007 level is frozen at the 2006 level. Additionally, beginning July 1, 2007, physicians who voluntarily report on certain quality measures may be eligible for bonus payments of 1.5%.

Table 3. Conversion Factors, 2000-2007

2000	$36.6137
2001	38.2581
2002	36.1992
2003*	36.7856
2004	37.3374
2005	37.8975
2006	37.8975
2007	37.8975

*Effective March 1, 2003.

[17] The 2006 conversion factor reflected the negative 4.4% update, as well as some other adjustments; the published 2006 amount was actually 4.5% less than the 2005 amount.

Changes Made by MMA, DRA, and the Tax Relief and Health Care Act

MMA included a number of provisions relating to physicians' services. It included changes in the calculations of the fee schedule, increased payments for the administration of covered drugs, and included requirements for a number of reports on physician payment issues. DRA revised the update calculation for 2006 and modified payments for imaging services. The Tax Relief and Health Care Act modified the calculation for 2007 and established a fund to promote payment stability and physician quality initiatives in 2008. (**For a summary of these provisions, see Appendix A.**)

Issues

2007 Fee Schedule

When the 2007 fee schedule regulation was released in November 2006, it was assumed that there would be a negative update in the conversion factor. Instead, the Tax Relief and Health Care Act of 2006 (P.L.109-432) froze the 2007 factor at the 2006 level. In addition, the law sets the work geographic adjustment level at a minimum of 1.0, thereby slightly increasing the payment amounts in some areas.

However, the rest of the 2007 fee schedule regulation continues to apply. It should be noted that this regulation incorporates several significant changes from 2006. First, it reflects the required five-year review of work relative values. Second, it incorporates the first year of a four-year phase-in of a revised methodology for calculating practice expenses. (See Appendix C.) Third, it includes the impact of the DRA mandated changes for payments for imaging services. (See discussion, below.)

The net impact of these changes for an individual physician will vary by the types and mix of services provided. The final rule for 2007 included a table showing, by specialty, the estimated impact of these changes.[18] CMS released this table again following enactment of the Tax Relief and Health Care Act of 2006. Without any change in the conversion factor, CMS estimated that five specialties would see an increase of 5% or more (emergency medicine, endocrinology, family practice, infectious diseases, and pulmonary diseases), while 10 specialties and practitioners would see a reduction of 5% or more (anesthesiology, interventional radiology, pathology, radiology, vascular surgery, chiropractors, clinical psychologists, clinical social workers, nurse anesthetists, and physical and occupational therapists). The largest reduction (13%) is for diagnostic testing facilities.

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[18] [http://www.cms.hhs.gov/physicianfeesched/downloads/1321-fc.pdf?agree=yes&next=Accept], pp. 728-729.

Calculation of the Update to the Conversion Factor

The law provides a specific formula, based in large measure on the SGR, for the annual calculation of the update to the conversion factor. Since 2002, application of this formula would have meant a negative update each year. Congress overrode the formula for 2003-2007. While in the short term, this prevented reductions in payments, the underlying problems with the formula have not been addressed. Generally, the short-term fixes actually increase the cost of a permanent fix. However, the law specifically provides that the fix for 2007 will be treated as never having occurred when the 2008 calculation is made.

Most observers state that the SGR should be replaced. They note that in the absence of legislation, negative updates will occur for the foreseeable future. Some persons state that physicians who have a large Medicare caseload will be unable to keep up with their practice costs. They further suggest that some physicians may be unwilling to accept new Medicare patients (see **Access** discussion).

Background on SGR. As noted earlier, the fee schedule was included in the Omnibus Budget Reconciliation Act of 1989 (OBRA 89, P.L. 101-239) in order to respond to two major concerns with the then existing reasonable charge payment methodology. First, observers noted that payments for individual services under the reasonable charge methodology were not related to the actual resources used. Second, they noted that overall Medicare payments for physicians' services were rising at a rapid pace. The fee schedule itself responded to the first concern by beginning to relate payments for individual services to actual resources used. However, a number of observers suggested that physicians could potentially respond to the cuts in payments for individual services by increasing the overall volume of services. As a result, enactment of the fee schedule itself might not slow the overall growth rate in expenditures.

The Congress responded to this concern by establishing, in OBRA 89, an expenditure target mechanism known as the Medicare Volume Performance Standard (MVPS). Under the MVPS, an annual expenditure target for physicians' services was established. The use of the target was intended to serve as a restraint on aggregate Medicare spending for physicians' services. If expenditures fell below the target in a year, the increase to the conversion factor in a future year would be larger than the MEI. Conversely, if expenditures were above the target in a year, the increase to the conversion factor in a future year would be less than the MEI.

Several statutory changes to the MVPS and conversion factor calculation rules were included in subsequent Medicare bills. Subsequently, the PPRC, among others, identified several methodological flaws with the revised MVPS system. The MVPS was replaced in 1999 by the SGR, in part based on PPRC recommendations. The SGR system is quite different from the MVPS. Under the MVPS system, a new MVPS was calculated each year, and a conversion factor update in a year was based on the success in meeting the target in a prior period.

The key difference between the MVPS and the SGR system is that the SGR system looks at cumulative spending since April 1, 1996; this was intended to eliminate some of the year to year fluctuations. However, the estimated $735.9

billion in actual spending from April 1, 1996 through December 31, 2006 far exceeds the cumulative $693.3 billion in allowed expenditures over the period. Under the current system, it would be very difficult to bring spending in below the cumulative target.

SGR Issues. Many observers contend that the SGR system is flawed and should therefore not be used in making the annual update calculation. In 2001, MedPAC, which replaced the PPRC, recommended that:

> ... the Congress replace the SGR system with an annual update based on factors influencing the unit costs of efficiently providing physician services. MedPac's recommendation would correct three problems. First, although the SGR system accounts for changes in input prices, it fails to account for other factors affecting the cost of providing physician services, such as scientific and technological advances and new federal regulations. Second, it is difficult to set an appropriate expenditure target with the SGR system because spending for physician services is influenced by many factors not explicitly addressed, including shifts of services among settings and the diffusion of technology. The SGR system attempts to sidestep this problem with an expenditure target based on growth in real GDP, but such a target helps ensure that spending is affordable without necessarily accounting for changes in beneficiaries' needs for care. Third, enforcing the expenditure target is problematic. An individual physician reducing volume in response to incentives provided by the SGR system would not receive a proportional increase in payments. Instead the increase would be distributed among all physicians providing services to Medicare beneficiaries.
>
> These problems with the SGR system can have serious consequences. Updates under the SGR system will nearly always lead to payments that diverge from costs because actual spending is unlikely to be the same as the target. When this occurs, payments will either be too low, potentially jeopardizing beneficiary access to care, or too high, making spending higher than necessary.[19]

Recommendations for Change. While there is general agreement that the SGR system needs to be replaced or modified, a consensus has not developed on a long-term solution. Part of the problem is that any permanent change is very costly. This reflects the fact that the CBO baseline (based on current law requirements) assumes a reduction in the conversion factor for the next several years. Budget considerations may continue to lead to short-term solutions, though at this writing Congress has not taken action to override the negative 2007 update. Several alternative approaches have been suggested. This section highlights proposals to change the way the update is calculated.

Replace Formula; Link Updates to Payment Adequacy. MedPAC's March 2002 report specifically recommended repeal of the SGR system. It recommended requiring the Secretary to update payments for physicians' services based on the estimated change in input prices for the coming year less an adjustment

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[19] Medicare Payment Advisory Commission, *Medicare in Rural America*, Report to Congress, June 2001.

for savings attributable to increased productivity. (A so-called "multifactor productivity" factor would be used.)[20]

Subsequent MedPAC reports have continued to recommend an update based on changes in input prices minus an adjustment for productivity growth. The March 2006 report recommended a 2007 update reflecting changes in input prices (estimated at 3.7%) minus an adjustment for productivity growth (estimated at 0.9%).[21]

MedPAC stated that the annual update should not be automatic, but should be linked to a number of factors including beneficiary access to services, the quality of services provided, and appropriateness of cost increases. MedPac noted that it used this approach in making its update recommendations. It noted that beneficiaries access to care, supply of physicians and the ratio of private payment rates to Medicare has remained stable. (See discussions, below). It concluded that current payment rates are adequate and should be updated by the projected change in physicians' costs less an adjustment for productivity growth.

Make Administrative Changes to Current Formula Calculation. While a change in the formula would require legislation, some observers have suggested that there are things CMS could do administratively to ease the impact of the current formula. Proponents argue that these changes could somewhat moderate the negative updates that are predicted. One change which has been suggested for several years is the removal of covered Part B prescription drugs from the SGR baseline (thereby removing this rapidly escalating cost factor from the calculation). However, CMS has consistently stated that it cannot make this change retrospectively without legislation. It further noted that making such a change would not result in a positive update for 2007 or the subsequent few years.

Modify Current Formula. Some persons have suggested modifying the current formula. GAO identified possible modifications to the current system, including using actual spending from a new, more recent base year (instead of 1996) for making the SGR calculation; eliminating the cumulative target mechanism and returning to a system of annual targets; and modifying the allowance for volume and intensity growth to more closely reflect technological innovation and changes in medical practice. It further noted that some of these options could be combined.[22]

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[20] There was a further problem with the SGR system. When CMS issued its December 2002 regulation for 2003, it stated that is was unable, under the then-existing law, to go back and revise previous estimates that were used in calculating the SGR for previous years. Errors in previous estimates meant that payment updates in some earlier years were higher than they should have been; in turn, this meant that spending was higher in those years than it would otherwise have been. Higher spending meant that updates in future periods were less in order to keep spending in line with the SGR target. The Consolidated Appropriations Resolution of 2003 (CAR, P.L. 108-7), enacted February 20, 2003, enabled CMS to revise FY1998 and FY1999 numbers; thereby resulting in a positive, rather than a negative, update for 2003.

[21] MedPAC, Mar. 2006.

[22] U.S. Government Accountability Office (formerly known as the General Accountability (continued...)

Volume Changes; DRA Report. It should be noted that a negative update to the conversion factor does not mean an overall reduction in physician spending. CBO estimates, using the current law update formula, that spending under the fee schedule will climb from $60.3 billion in FY2006 to $63.6 billion in 2011.[23] While part of the increase is attributable to increasing numbers of beneficiaries, part reflects the increased volume of services per beneficiary.

Volume changes reflect both changes in the number of services and the complexity or intensity of services. Volume increased by 6.2% between 2003 and 2004; the largest increase was recorded for imaging services which increased 11%.[24] Part of the increases in volume may be attributable to beneficial uses of new technology; however, not all increases may be appropriate.

DRA requires MedPAC to conduct a study and report to Congress by March 1, 2007 on its recommendations for mechanisms that could be used to replace the SGR system. The study is required to review options for controlling volume while still maintaining beneficiary access to services.

Evidence-Based Medicine; Quality Reporting

Increased volume is not the only concern facing policy makers. Another relates to the wide geographic variations in the number and intensity of services provided, even among physicians in the same specialty. Analyses of these geographic variations shows that increased service use does not necessarily translate into increased quality or improved health outcomes.

Some observers recommended incorporating quality measurements into the payment calculation. Quality measurements would be based on evidence-based medicine. Physicians with higher quality performance would be paid more while those with lower quality performance would be paid less. Some have labeled this "pay for performance" (or "P4P").

For a discussion of Medicare P4P initiatives and issues, see CRS Report RL33713*, Pay-for-Performance in Health Care,* by Jim Hahn.

In January 2006, CMS launched the Physician Voluntary Reporting Program (PVRP). Under this program, physicians who choose to participate report on 16 evidence-based quality measures. They are able to receive feedback on their performance, as well as provide input on how quality reporting could be improved. The list of quality measures is to be modified and expanded in 2007.

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[22] (...continued)
Office), *Medicare Physician Payments: Concerns About Spending Target System Prompt Interest in Considering Reforms*, Oct. 2004.

[23] CBO, Mar. 2006 baseline.

[24] MedPAC, Mar. 2006.

The Tax Relief and Health Care Act of 2006 provides a bonus payment for physicians who report on quality measures. Specifically, physicians and practitioners who voluntarily report quality information will be eligible for a bonus incentive payment. For services furnished from July 1, 2007-December 31, 2007, the bonus is 1.5% of allowed charges for services for which consensus-based quality measures have been established. The quality measures are those identified under the PVRP, as published on the CMS website on December 20, 2006 (the date of enactment). The Secretary can modify these quality measures if changes are based on the results of a consensus process meeting in January 2007, and if such changes are published on the website by April 1, 2007. The Secretary may refine such measures up until July 1, 2007.

If there are no more than three quality measures applicable to the services furnished, the provider must report each measure for at least 80% of the cases. If there are four or more quality measures, the provider must report at least three for at least 80% of the cases. The Secretary is to estimate, based on submitted claims, an amount equal to 1.5% of allowed charges for services for which reports have been made. A single consolidated payment is to be made to the physician for the July 1, 2007-December 31, 2007, reporting period.

In 2008, the quality measures are those that have been adopted or endorsed by a consensus organization, that include measures submitted by a physician specialty, and the Secretary identifies as having used a consensus-based process for developing the measures. The measures are to include structural measures such as the use of electronic health records and electronic prescribing technology. The proposed measures for 2008 are to be published by August 15, 2007, with final measures published by November 15, 2007. The legislation does not specifically link quality reporting to bonus payments for 2008.

The law authorizes $1.35 billion for 2008 for a Physician Assistance and Quality Initiative Fund, which is to be available to the Secretary for physician payment and quality improvement initiatives. The initiatives may include adjustments to the conversion factor.

Cost of Reform Options

CBO estimated that the Tax Relief and Health Care Act of 2006 Act provision freezing the 2007 conversion factor at the 2006 level and providing bonus payments for quality reporting for last half of 2007 will cost $3.1 billion over the FY2007-FY2008 period.[25] Unlike previous laws averting a negative update, this legislation specifically states that the 2007 change is to be treated as never having occurred when the 2008 calculation is made.

A permanent fix would be more costly than a temporary one-year or two-year fix. In April 2006, CBO estimated that replacing the SGR formula with an increase

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[25] CBO, *H.R. 6111, Tax Relief and Health Care Act of 2006*, December 28, 2006. [http://www.cbo.gov/ftpdocs/77xx/doc7714/hr6111pgo.pdf].

tied to the Medicare economic index (MEI) would cost $58 billion over the FY2007-FY2011 period and $218.2 billion over the FY2007-FY2016 period.

Imaging Services

MedPAC and other observers have expressed concerns that sizeable volume increases, particularly for imaging services, needs to be addressed. DRA modified the payment rules for certain imaging services. Specifically, the law caps the technical component of the payment for services performed in a doctor's office at the level paid to hospital outpatient departments for such services. The limitation does not apply to the professional component (i.e., the physician's interpretation). Services subject to the cap are: X-rays, ultrasound (including echocardiography), nuclear medicine (including positron emission tomography), magnetic resonance imaging, computed tomography, and fluoroscopy. Diagnostic and screening mammography are excluded. The provision is effective January 1, 2007.

A number of groups objected to the payment cuts. On March 1, 2006, a coalition of 30 medical groups, technology associations, providers and others sent a letter to House and Senate leaders asking for a reconsideration of the provision. They contended that the cuts could have unintended consequences, including potentially diminishing access to imaging services outside of the hospital setting.

Impact of Spending Increases on Part B Premiums

Payments for physicians' services account for close to 50% of Part B costs.[26] Increased spending on physicians' services therefore has a considerable impact on overall Part B costs, and by extension on the amount beneficiaries are required to pay in monthly Part B premiums.

By law, beneficiary premiums equal 25% of Part B program costs. The 2005 premium ($78.20) represented a 17.4% increase over the 2004 premium ($66.60). The 2006 premium ($88.50) is 13.2% over the 2005 amount. The 2007 premium ($93.50) is 5.6% over the 2006 amount.

The 2006 amount was computed prior to passage of the DRA provision preventing a negative update to the conversion factor. This provision has the effect of increasing Part B costs and by extension, the Part B premium. The increase is first reflected in the 2007 premium amount.

Access to Care

Questions have been raised about beneficiaries continued access to care. In 2002, the year the conversion factor was cut, press reports in many part of the country documented many cases where beneficiaries were unable to find a physician because physicians in their area were refusing to accept new Medicare patients. Despite slight increases in the updates for 2003, 2004, and 2005, (and the freeze in 2006), some

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[26] For a discussion of Part B premiums, see CRS Report RL32582, *Medicare: Part B Premiums*, by Jennifer O'Sullivan.

physicians claim that program payments continue to fall significantly short of expenses. They suggest that problems will be magnified if the cuts, scheduled to begin in 2007, are allowed to go into effect.

Access to care can be measured by reviewing beneficiary ability to get an appointment with a physician, the supply of physicians seeing Medicare patients, and physicians' willingness to see new patients.

Access. Periodic analyses by MedPAC and CMS show that beneficiary access to physicians' services is generally good. MedPAC's 2006 report reviewed several surveys conducted between 2003 and 2005.[27] The surveys compared access for Medicare beneficiaries with that for privately insured persons age 50 to 64. It noted that for both groups access to physicians was good and for some indicators was slightly better for the Medicare population. The large majority of Medicare beneficiaries (87%) had no problem or only a small problem in getting an appointment with a new primary care physician, while 13% reported a big problem. Among those with an appointment, 95% never or rarely had to wait longer than they wanted to get an appointment for routine care and 98% never or rarely had to wait for care to treat an illness or injury.

Similar results were obtained from the CMS-sponsored Consumer Assessment of Health Plans Survey for Medicare fee-for-service (CAHPS-FFS). In that survey, almost all (95%) beneficiaries in 2004 reported having small or no problems receiving care they or their doctor thought necessary and 91% were able to schedule an appointment for regular or routine care as soon as they wanted. A second survey by CMS targeted 11 market areas suspected of access problems. This Targeted Beneficiary Survey, conducted in 2003 and 2004, found that even in these selected areas, only a small percentage of patients had access problems attributed to physicians not taking new patients.[28]

Physician Supply. MedPAC reports that the growth in the number of physicians regularly billing Medicare fee-for-service patients has more than kept pace with the recent growth in the Medicare population. MedPAC reports that in 2004, 483,945 physicians regularly billed Medicare, accounting for 12.5 physicians per 1,000 Part B Medicare beneficiaries. This represents an increase from the physician population ratio of 11.7 recorded in 1999. Over the 1999-2004 period, Part B enrollment grew 4.8%, the number of physicians with 15 or more Medicare patients grew 11.9%, and the number with 200 or more Medicare patients grew 20.7%.

Physicians' Willingness to See New Beneficiaries. A related concern is the possible decline in the percentage of physicians accepting new Medicare patients. However, MedPAC reports that the large majority of physicians in the U.S. are willing to accept new Medicare patients. It cites results from a 2004-2005 survey by HSC showing that only 3% of practices open to new private patients completely closed their practices to new Medicare patients, while 73% reported that they accepted all new Medicare patients.

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[27] MedPAC, Mar. 2005.

[28] MedPAC, Mar. 2006.

GAO Study. MMA required GAO to study and report to Congress on beneficiary access to physicians' services. The study was issued in July 2006.[29] It found that from 2000 through 2004, among beneficiaries who needed access to physician services, the percentages reporting major difficulties in finding a provider or being able to schedule an appointment remained relatively constant (about 7% nationwide). Similar percentages were reported for urban and rural beneficiaries. Beneficiaries who rated their health as poor, were under 65 and disabled, were not white, and had no supplemental health insurance or had supplemental insurance from Medicaid, were more likely to have experienced physician access difficulties. GAO further noted that the proportion of beneficiaries who received services and the number of services provided to beneficiaries who were treated suggested an increase in access from April 2000 to April 2005.

Future Prospects. While access remains good for Medicare beneficiaries, many observers are concerned that the situation could change if future cuts slated to occur through application of the SGR methodology are allowed to occur. MedPAC does not support the consecutive annual cuts called for in the law. It is concerned that such cuts could threaten beneficiary access to physicians' services over time, particularly those provided by primary care physicians.

In March 2006, the AMA announced the results of its recent physician survey. It stated that if the 2007 cuts were allowed to go into effect, 45% would decrease or stop seeing new Medicare patients. As noted, Congress blocked the 2007 cuts.

Geographic Variation in Payments

Geographic Cost Indices. Medicare makes a geographic adjustment to each component of the physician fee schedule.[30] This adjustment is intended to reflect the actual differences in the costs of providing services in various parts of the country. Recently some observers, particularly those in states with lower than average payment levels, have objected to the payment variation. In part, this may reflect the concern with the overall reduction in payment rates in 2002, the small updates in 2003-2005, the freeze in 2006 and 2007, and the prospects of further reductions in future years.

MMA made a temporary changes to the geographic adjusters. It raised the geographic adjustment for the work component of the fee schedule to 1.000 in any area where the multiplier would otherwise be less. This provision applied from 2004 - 2006. The Tax Relief and Health Care Act of 2006 extended the provision for an additional year - through 2007.

MMA further directed the GAO to conduct a study of the geographic adjusters. A GAO report issued in March 2005 concluded that all three adjusters were valid in their fundamental design, and appropriately reflected broad patterns of geographic

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[29] GAO, *Medicare Physician Services: Use of Services Increasing Nationwide and Relatively Few Beneficiaries Report Major Access Problems,* GAO-06-704, July 21, 2006.

[30] See Appendix A for a discussion of how these adjustments are calculated.

differences in running a practice. The report made several recommendations for improving the data and methods used to construct the data. CMS stated that implementing many of the recommendations was not feasible at this time.[31]

State-by-State Variation. Some have also suggested that states with lower than average per capita payments (excluding managed care payments) for all Medicare services are being shortchanged. It should be noted that the variations reflect a variety of factors, few of which can be easily quantified. These include variations in practice patterns, size and age distribution of the beneficiary population, variations in managed care penetration, the extent to which populations obtain services in other states, and the extent to which other federal programs (such as those operated by the Department of Defense or Veterans Affairs) are paying for beneficiaries care. For these reasons, CMS considers state-by-state Medicare spending data misleading and is therefore no longer publishing this data.

Payment Localities. Geographic adjustments are applied by payment locality. There are currently 89 localities; some are statewide, while others are substate areas. Some observers have recommended that changes be made to the composition of some of the current localities; for example, they state that costs in a particular community significantly exceed those in other parts of the same locality.

CMS has stated that it will consider requests for locality changes when there is demonstrated consensus within the state medical association for the change. It should be noted that any changes must be made in a budget-neutral fashion for the state. Thus, if higher geographic practice cost indices (and thus payments) are applied in one part of the state, they must be offset by lower indices (and payments) in other parts of the state.

California Issues. Two counties in California (Santa Cruz and Sonoma) are assigned to a larger payment locality ("rest of California"). As a result, they have geographic payment adjusters that are much lower than would be in place if they had county-specific adjusters. Their adjusters are also substantially lower than those applicable in neighboring counties. In the August 8, 2005 proposed physician fee schedule, CMS offered a proposal to address the problem. However, it failed to win the support of the majority stakeholders because offsetting reductions would be required in other areas. The final regulation, therefore, includes no change for 2006.

Medicare Versus Private Payment Rates

Some persons contend that Medicare payments lag behind those in the private sector. MedPAC's 2006 report notes that a contractor to MedPAC found that the difference between Medicare and private rates narrowed in the late1990s and has remained relatively stable in recent years. Averaged across all services and areas, the 2004 rates were 83% of private fees (compared to 81% in 2003). It should be noted that difference in fees can vary markedly within a market area and for a given service.

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[31] U.S. GAO, *Medicare Physician Fees: Geographic Adjustment Indices are Valid in Design, but Data and Methods Need Refinement*, GAO Report 05-119, Mar. 2005.

Payments for Oncology Services

Background. The level of payments for practice expenses became a major issue for oncologists who frequently administer chemotherapy drugs in their offices. Prior to the implementation of the new Medicare drug program under Part D, Medicare did not cover most outpatient prescription drugs. However, certain categories of these drugs have been and continue to be covered under Part B. Included are drugs that cannot be self-administered and which are provided as incident to a physician's service, such as chemotherapy. Medicare Part B also covers certain oral cancer drugs. Covered drugs are those that have the same active ingredients and are used for the same indications as chemotherapy drugs which would be covered if they were not self-administered and were administered as incident to a physician's professional service.

Prior to enactment of MMA, a number of reports, including those by the HHS Office of Inspector General, the Department of Justice (DOJ), and GAO had found that Medicare's payments for some of these drugs were substantially in excess of physicians' and other providers' costs of acquiring them. However, oncologists had stated that the overpayments on the drug side were being used to offset underpayments for practice expenses associated with administration of the chemotherapy drugs.

MMA Changes. MMA sought to rationalize program payments. It increased the payments associated with drug administration services. At the same time, it revised the way covered Part B drugs are paid.[32] In 2004, a modified version of the existing average wholesale price methodology was used. Beginning in 2005, drugs are paid using the average sales price (ASP) methodology. Drug payments are less under the new system. A transitional payment was authorized in 2004 and 2005 to ease the adjustment.

Many observers suggested that changes to the drug payment methodology were long overdue and that reductions were in order given the previous overpayments. However, many oncologists stated that the revised payment methodologies would lead to a net loss in Medicare payments.

CMS took a number of actions designed to respond to the oncologists' concerns. Beginning in 2005, it made a number of modifications in coding and payment for drug administration services, which allowed for higher payments in a number of cases.

Also in 2005, CMS initiated a national oncology one-year demonstration project focusing on three areas of concern for cancer patients: pain, nausea and vomiting, and fatigue. Practitioners participating in the demonstration had to provide information (using new temporary billing codes) to describe a chemotherapy patient's status with respect to these three areas. Any oncologist could participate in the

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[32] See CRS Report RL31419, *Medicare: Payments for Covered Part B Drugs*, by Jennifer O'Sullivan.

demonstration; those who did received $130 per patient per day. CMS estimated that this demonstration would increase payments in 2005 by about $300 million.

In November 2005, CMS announced a revised demonstration project for 2006. It described the new one-year project as furthering its efforts toward improving quality care and promoting evidence-based practices that have been shown to lead to improved patient outcomes. Under the 2006 demonstration, hematologists/oncologists who provide evaluation and management services to established patients with one of 13 specified primary cancer diagnoses will report (using new temporary codes) on: (1) the primary focus of the service (for example, supervision of therapy and attendant toxicity management); (2) the current disease state; and (3) whether the current management adheres to clinical guidelines. The physician may report that the guidelines are being followed or not followed — for example, a case when there was an alternative treatment due to patient preference or when the physician did not agree with the guidelines. Physicians who report in all three categories will qualify for an additional $23 in addition to the payment for the visit.

When CMS announced the 2007 fee schedule on November 1, 2006, it stated it had not yet made a decision on whether or not to extend the demonstration. Earlier, in August 2006, the HHS Office of the Inspector General (OIG) issued a report on the 2005 demonstration. That report stated that 7% of demonstration claims did not comply with program rules or were paid incorrectly. Further, CMS did not sufficiently define the parameters of the demonstration, leading to inconsistent data collection and incomplete and unreliable data. As a result, the OIG concluded that the demonstration data were unreliable.[33]

Impact. CMS estimated that for 2004, the increases on the practice expense side balanced the reductions on the drug side. For 2005, CMS estimated that a 10% increase for drug administration services (accounting for an estimated 28% of oncologist revenues) would be offset by a reduction of 13% in drug revenues (which accounted for 69% of oncologists' total revenues). The net impact was a reduction of 6% from 2004 to 2005, assuming constant utilization. However, CMS, using historical trends in volume, assumed an increase in utilization, thereby increasing revenues by 8%.[34]

For 2006, CMS estimated a 10% reduction in revenues under the physician fee schedule and monies from the demonstration (accounting for an estimated 28% of oncologist revenues), and no change in revenues from drugs (accounting for an estimated 70% of revenues), resulting in an overall 3% reduction. However, CMS estimated that there would be no overall change because of the continued increase in

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[33] Department of Health and Human Services, Office of the Inspector General, *Cost and Performance of Medicare's 2005 Chemotherapy Demonstration Project*, OEI-09-05-00171, August 2006.

[34] Centers for Medicare and Medicaid Services, "Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2005; Final Rule," 69 *Federal Register* 66235, Nov. 15, 2004.

utilization. However, some oncologists continue to express concerns about payment levels and, by extension, access.

MMA required MedPAC to review oncology payment changes made by MMA with an emphasis on quality, beneficiary satisfaction, adequacy of reimbursement, and impact on physician practices. The study was issued January 2006.[35] The report found that following historical trends, the use of chemotherapy drug administration services and chemotherapy drugs increased in 2004 and 2005. Oncologists provided more chemotherapy sessions in 2005 and more individuals received chemotherapy in physicians' offices. Medicare paid less for the drugs in 2005, though the volume of drugs increased. Further, the mix of drugs moved toward newer, more expensive, agents.

MedPAC further noted that all physicians practices considered the MMA changes significant. They responded by cutting costs, increasing efficiency, finding new sources of revenue, or selecting more profitable patients. A number of the physicians cited the demonstration project as enabling them to continue to provide care. However, the presence of the project made it difficult to evaluate the effects of the payment changes.

It should be noted that the HHS Office of Inspector General issued a report[36] stating that the way CMS calculated average sales prices for Part B drugs (including oncology drugs) resulted in overpayments for a number of these drugs. In response, CMS indicated that it is not revising its methodology at this time, though it may revise its policy as more information becomes available over time.

Concierge Care

In the past couple of years, some physicians have altered their relationship with their patients. Some doctors, in return for additional charges, offer their patients additional services such as round the clock access to physicians, same-day appointments, comprehensive care, additional preventive services, and more time spent with individual patients. In return, patients are required to pay a fee or retainer. This practice has been labeled "concierge care." Patients who do not pay the additional charges typically have to find another doctor.

Some physicians see concierge care as a way of permitting them to spend more time with individual patients as well as a way to increase their income. However, questions have been raised regarding the implications of concierge care for patients, particularly Medicare beneficiaries. One concern is that while wealthier patients might be able to afford the additional costs, other patients might find it more difficult to gain access to needed services.

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[35] MedPAC, *Effects of Medicare Payment Changes on Oncology Services*, Report to the Congress, Jan. 2006.

[36] HHS, Office of the Inspector General, *Calculation of Volume-Weighted Average Sales Price for Medicare Part B Prescription Drugs*, Report OEI-03-05-00310, Feb. 2006.

The Office of Inspector General (OIG) issued an OIG Alert on March 31, 2004. The Alert reminded Medicare participating physicians about the potential liabilities posed by billing for services already covered by Medicare. Participating physicians can bill their patients for the requisite coinsurance and deductibles as well as for uncovered services. However, the Alert noted that it had been brought to the OIG's attention that some concierge contract services, while described as uncovered services, were actually services covered by Medicare. This would be in violation of the physician's assignment agreement and could subject the physician to civil monetary penalties.

Prospects

Since the problems raised by the SGR formula have not been permanently addressed, it is likely that the 110th Congress will examine various alternative solutions.

Appendix A. MMA, DRA, and Tax Relief and Health Care Act Provisions Relating to Physicians

MMA Fee Schedule Modifications

MMA made several changes in the calculation of the fee schedule. Over the short term, generally 2004-2005, these were designed to increase program payments to physicians. They did not, however, address the underlying problems with the formula used to calculate program payments under the fee schedule.

- The update to the conversion factor could be no less than 1.5% in 2004 and 2005. (Section 601(a) of MMA.)
- The formula for calculating the sustainable growth rate (SGR) was modified by replacing the existing GDP factor (which measured a one year change from the preceding year) to a 10-year rolling average. (Section 601(b) of MMA.)
- The geographic index adjustments in Alaska for the work component, practice expense component and malpractice component were each raised to 1.67 for 2004 and 2005. This resulted in an increase in payments to Alaska physicians in these years. (Section 602 of MMA.)
- A floor of 1.00 was set on the geographic work adjustment for the 2004-2006 period. (Section 412 of MMA.)
- An additional 5% in payments was provided for certain physicians in scarcity areas for the period January 1, 2005-December 31, 2007. The Secretary was required to identify those areas with the lowest ratios of physicians to beneficiaries, which collectively represent 20% of the total Medicare beneficiary population in those areas. The list of counties would be revised no less often than once every three years unless there was no new data. (Section 413 of MMA.)

The following table summarizes CBO's estimates of the impact of these provisions, excluding those with no costs or costs below the threshold.

Table 4. Changes in Direct Spending Attributable to Selected MMA Physician-Related Provisions

(in billions)

Provision		Spending increases	
Topic	**Section**	**FY2004-FY2008**	**FY2004-FY2013**
Update revisions	601	$2.4	$0.2
Alaska	602	$0.1	$0.1
Floor on work component	412	$1.0	$1.0
Bonus payments	413	$0.7	$0.7

MMA Changes in Payments for Drug Administration Services

MMA revised the way covered Part B drugs were paid under the program; this had the effect of lowering program payments for the actual drugs. At the same time, MMA increased the payments associated with drug administration services. These provisions affected selected specialties, primarily oncologists.

The following highlight the MMA changes made in payments for drug administration services. Many of the provisions were very technical; in general they resulted in higher payments. The net impact was an overall increase in payments. (Section 303(a) of MMA.) The MMA changes in the payment methodology for covered Part B drugs is contained in a companion CRS report.[37]

- Beginning in 2004, the practice expense relative value units for oncology services were to be adjusted using survey data that was submitted to the Secretary by January 1, 2003. (This data which was submitted by the American Society of Clinical Oncologists (ASCO) showed higher costs than previously assumed by CMS in its calculations.) The additional expenditures were exempt from the budget neutrality adjustment for 2004.
- Beginning in 2004, the work relative value units for drug administration services were equal to the work relative value units for a level one office medical visit for an established patient. Drug administration services were defined as those classified as of October 1, 2003, within the following groups of procedures but for which no work relative value unit had been assigned: therapeutic or diagnostic infusions (excluding chemotherapy); chemotherapy administration services; and therapeutic, prophylactic, or diagnostic injections. This resulted in an increase in payments, since these services previously had no work relative value units assigned.
- In 2005 and 2006, the practice relative value units for other drug administration services were to be increased using appropriate supplemental survey data submitted by March 1, 2004, for 2005 and March 1, 2005, for 2006. Data was to be accepted only for those specialties that received 40% or more of their Medicare payments from drugs and biologicals in 2002, and would not apply to the ASCO survey submitted by January 1, 2003. The additional expenditures are exempt from the budget neutrality adjustment for 2005 and 2006.
- The Secretary was required to promptly evaluate drug administration codes to ensure accurate reporting and billing. The codes would be evaluated under existing processes and in consultation with interested parties. The additional expenditures were to be exempt from the budget neutrality adjustment for 2005 and 2006.

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[37] CRS Report RL31419, *Medicare: Payments for Covered Part B Drugs*, by Jennifer O'Sullivan.

- Other services paid under the nonphysician work pool methodology (applicable to services for which no work relative values had been assigned) were to be unchanged by the MMA changes.
- Medicare's payment policy, in effect on October 1, 2003, for the administration of more than one drug or biological through the push technique, was to be reviewed. Any resulting modification would be exempt from the budget neutrality requirement in 2004.[38]
- The drug administration payments otherwise calculated were to be increased by 32% in 2004 and 3% in 2005. This was labeled a transitional adjustment and was intended to offset the effects of the reduction in payments for covered Part B drugs.
- The Secretary was prohibited from making payment adjustments for drugs in 2004, unless a concurrent adjustment is made in the calculation of practice expenses as required by Section 303(a). (Section 303(f) of MMA.)

It should be noted that Section 303(j) of MMA limited the application of Section 303 to the specialties of hematology, hematology/oncology, and medical oncology. Section 304 of MMA specified that the provisions of Section 303 apply to other specialties. As noted in the conference report on the bill, this allowed CBO to provide one estimate for the impact of the provisions on oncologists and another estimate for the impact on other specialties.

CBO estimated that for oncologists under Section 303, the net impact of the revisions in the payment for drugs coupled with the increases in payments for the administration of drugs was a savings of $0.9 billion over the 2004-2008 period and $4.2 billion over the 2004-2013 period. For other specialties, the savings under Section 304 totaled $2.2 billion over the 2004-2008 period and $7.3 billion over the 2004-2013 period.

MMA Studies and Reports

MMA also required a number of studies and reports relating to physicians' services. These were intended to provide Congress with additional information as it considered revisions in the current payment formula.

MMA required the following studies and reports relating to physicians' services.

- MedPAC was required to review the payment changes made under Section 303 (drug administration and payment) and report to Congress by January 1, 2006, on: the quality of care furnished to individuals; their satisfaction with care; the adequacy of reimbursement taking into account geographic variation and practice size; and the impact on physician practices. MedPAC was required to conduct a similar study for drug administration services furnished

[38] CMS modified the policy, effective January 1, 2004, to allow for the billing for drug administration through the push technique once per day for each drug administered.

by other specialties; the report is due January 1, 2007. (Section 303(a) of MMA.)

- GAO was required to study and submit a report to Congress by June 8, 2005, on beneficiary access to physicians' services, including changes in such access over time. (Section 604 of MMA.)
- The Secretary was required to review and consider alternative data sources other than those currently used to establish the geographic index for the practice expense component under the physician fee schedule. The report is due to Congress by January 1, 2006. (Section 605 of MMA.)
- MedPAC was required to submit a report to Congress by December 8, 2004, on the effects of the refinements to the practice expense component after transition to the full resource-based system in 2002. Also by December 8, 2004, MedPAC was required to submit a report to Congress on the extent to which increases in the volume of services under Part B are the result of care that improves the health and well-being of beneficiaries. (Section 606 of MMA.)
- MedPac was required to study and report to Congress by January 1, 2005 on the feasibility and advisability of paying for surgical first assisting services furnished by a certified registered first nurse assistant under Part B. (Section 643 of MMA.)
- MedPAC was required to study and report to Congress by January 1, 2005, on the practice expense relative values for cardio-thoracic surgeons to determine if the values adequately take into account the attendant costs such physicians incur in providing clinical staff for patient care in hospitals. (Section 644 of MMA.)
- The GAO was required to study and report to Congress by December 8, 2004, on the propagation of concierge care and its impact on beneficiaries. (Section 650 of MMA.)

Other MMA Changes

MMA included a number of additional provisions relating to physicians' services, including:

- Podiatrists, dentists, and optometrists were permitted to enter into private contracting arrangements. (Section 603 of MMA.)
- Medicare payments could be made to an entity which has a contractual relationship with the physician or other entity (namely a staffing entity). The entity and the contractual arrangement would have to meet program integrity and other standards specified by the Secretary. (Section 952 of MMA.)
- The Secretary was required to use a consultative process prior to implementing any new documentation guidelines for evaluation and management (i.e., visit) services. (Section 941 of MMA)
- MMA contained a number of additional provisions designed to address physicians' concerns with regulatory burdens. (Title IX of MMA.)

DRA Fee Schedule and Related Changes

DRA froze the 2006 fee schedule at the 2005 level. It also required MedPAC to submit a report to Congress by March 1, 2007 on mechanisms that could be used to replace the sustainable growth rate system. The report is to (1) identify and examine alternative methods for assessing volume growth; (2) review options to control the volume of physicians' services under Medicare while maintaining access for beneficiaries; (3) examine the application of volume controls under the fee schedule; (4) identify levels of application of volume controls such as group practice, hospital medical staff, type of service, geographic area, and outliers; (5) examine the administrative feasibility of implementing options under (2), including the availability of data and time lags; (6) examine the extent to which the alternative methods identified and examined under (1) should be specified; and (7) identify the appropriate levels of discretion for the Secretary of HHS to change payment rates under the fee schedule or to otherwise take steps that affect physician behavior. The report is to include recommendations on alternative mechanisms to replace the SGR. The section appropriates $550,000 from the Treasury, out of amounts not otherwise appropriated, to MedPAC to carry out the study.

DRA also modifies payments for imaging services. It caps the technical component of the payment for services performed in a doctor's office. The cap is set at the outpatient department (OPD) fee schedule amount (without regard to the geographic wage adjustment factor) under the prospective payment system for hospital outpatient departments. The limitation does not apply to the professional component (i.e., the physician's interpretation). Services subject to the cap: X-rays, ultrasound (including echocardiography), nuclear medicine (including positron emission tomography), magnetic resonance imaging, computed tomography, and fluoroscopy. Diagnostic and screening mammography are excluded. The provision is effective January 1, 2007. The law also includes a technical provision specifying that an earlier regulation change made by CMS for multiple imaging procedures is not to be taken into account in making the budget neutrality calculation for 2006 and 2007.

Tax Relief and Health Care Act of 2006 Changes

P.L.109-432 freezes the 2007 fee schedule at the 2006 level. It also provides a bonus payment for physicians who report on quality measures. Specifically, physicians and practitioners who voluntarily report quality information will be eligible for a bonus incentive payment. For services furnished from July 1, 2007 - December 31, 2007, the bonus is 1.5% of allowed charges for services for which consensus-based quality measures have been established. The quality measures are those identified under the Physician Voluntary Reporting Program (PVRP), as published on the CMS website on December 20, 2006 (the date of enactment). The Secretary can modify these quality measures if changes are based on the results of a consensus process meeting in January 2007 and if such changes are published on the website by April 1, 2007. The Secretary may refine such measures up until July 1, 2007.

If there are no more than 3 quality measures applicable to the services furnished, the provider must report each measure for at least 80% of the cases. If there are 4 or more quality measures, the provider must report at least 3 for at least 80% of the cases. The Secretary would presume that if an eligible professional submits data for a measure, then the measure is applicable to the professional. The Secretary may validate this presumption by sampling or other means.

The Secretary is to estimate, based on submitted claims, an amount equal to 1.5% of allowed charges for services for which reports have been made. A single consolidated bonus payment is to be made to the physician for the July 1, 2007 - December 31, 2007 reporting period. No provider could receive payments in excess of the product of the total number of quality measures for which data are submitted and three times the average per measure payment amount. The average per measure payment amount (as estimated by the Secretary) is the total amount of allowed charges under Part B for all covered services furnished during the reporting period on claims for which quality measures are reported divided by the total number of quality measures for which data are reported during the reporting period.

In 2008, the quality measures are those that have been adopted or endorsed by a consensus organization, that include measures submitted by a physician specialty, and the Secretary identifies as having used a consensus-based process for developing the measures. The measures are to include structural measures such as the use of electronic health records and electronic prescribing technology. The proposed measures for 2008 are to be published by August 15, 2007, with final measures published by November 15, 2007.

The law authorizes $1.35 billion for 2008 for a Physician Assistance and Quality Initiative Fund which is to be available to the Secretary for physician payment and quality improvement initiatives. The initiatives may include adjustments to the conversion factor. The provision also requires transfer of $60 million from the Part B trust fund to the CMS program management account for use in implementing the fee schedule and reporting provisions for FY2007 - FY2009.

The law also extends for an additional year the MMA provision setting a floor of 1.00 on the geographic component of the work adjustment.

Appendix B. Geographic Adjustments to the Physician Fee Schedule

Section 1848(e) of the Social Security Act requires the Secretary of the Department of Health and Human Services (HHS) to develop indices to measure relative cost differences among fee schedule areas compared to the national average. Three separate indices are required — one for physician work, one for practice expenses and one for malpractice costs. The law specifies that the practice expense and malpractice indices reflect the full relative differences. However, the work index must reflect only *one-quarter* of the difference. Using only one-quarter of the difference generally means that rural and small urban areas would receive higher payments and large urban areas lower payments than if the full difference were used. The indices are updated every three years and phased-in over two years.

Legislative Background

The physician fee schedule represented the culmination of several years of examination by the Congress, HHS, and other interested parties on alternatives to the then existing charge-based reimbursement system. In 1986, Congress enacted legislation providing for the establishment of the Physician Payment Review Commission (PPRC) to provide it with independent analytic advice on physician payment issues. A key element of the Commission's charge was to make recommendations to the Secretary of HHS respecting the design of a relative value scale for paying for physicians' services. The Commission's March 1989 report presented the Commission's proposal for a fee schedule based primarily on resource costs. It recommended that the initial basis for the physician work component should be the work done by William Hsiao and his colleagues at Harvard University.

The 1989 PPRC report examined issues related to geographic variations. It noted that adjustments could be made to reflect nonphysician inputs (overhead costs such as office space, medical equipment, salaries of nonphysician employees, and malpractice insurance) and physician inputs of their own time and effort (which is generally measured by comparing earnings data of nonphysicians). It concluded that:

> Payments under the fee schedule should vary from one geographic locality to another to reflect variation in physician costs of practice. The cost-of-living practice index underlying the geographic multiplier should reflect variation only in the prices of nonphysician inputs.[39]

PPRC stated that the fee schedule should only reflect variation in overhead costs. Other observers, however, suggested that since physicians, as well as other professionals, compete in local markets, local market conditions should be reflected in the payments.

Three congressional committees have jurisdiction over Medicare Part B (which includes physicians' services). These are the House Energy and Commerce, House Ways and Means, and Senate Finance. Each of these committees considered

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[39] Physician Payment Review Commission, *Annual Report to Congress, 1989*.

differing versions of the physician fee schedule as part of the budget reconciliation process in 1989. Both the Ways and Means Committee measure and the Senate Finance Committee measure included a geographic adjustment for the overhead and malpractice components of the fee schedule, but not for the physician work component. However, the Energy and Commerce Committee version provided for an adjustment. The Committee noted:

> The PPRC, in its annual report for 1989, recommended that the physician work effort component of the fee schedule not be adjusted at all for geographic variations, on the grounds that the physician's time and effort should be given the same valuation everywhere in the country. The Committee does not agree with this recommendation. The Committee recognizes that the cost-of-living varies around the country and that other professionals are compensated differently, based on where they perform their services. The Committee is concerned that, if no adjustment is made in the physician work effort component, fees in high cost areas may be reduced to such an extent that physician services in such areas would become inaccessible. The Committee is also concerned, however, that a full adjustment of this component, in accord with the index developed by the Urban Institute, would be disadvantageous to the low valuation areas and would not serve the Committee's policy goal of fostering a better distribution of physician personnel. Fees in those areas might be too low to attract physicians and to resolve problems of access that have occurred.
>
> The index chosen by the Committee tries to balance these concerns. It makes the adjustment in the physician work effort component, but cuts the impact of the original Urban Institute index in half .... [40]

The 1989 budget reconciliation bill passed by the House included both the Ways and Means Committee and Energy and Commerce Committee versions of reform. The Senate Finance Committee version was not in the Senate-passed version because all Medicare and non-Medicare provisions which did not have specific impact on outlays (and therefore could not withstand a point of order based on the "Byrd rule") were struck from the Senate bill. Since the physician payment reform provisions were designed to be budget neutral they were not included. Therefore, the Senate physician fee schedule provisions were not technically in conference.

After considerable deliberation, the conference committee approved a reconciliation bill which included physician payment reform. The conference agreement provided that one-quarter of the geographic differences in physician work would be reflected in the fee schedule. The accompanying report described the provision but contained no discussion of this issue.

MMA contained several provisions relating to the geographic calculations. The law set a floor of 1.0 on the work adjustment for the 2004-2006 period. The Tax Relief and Health Care Act of 2006 (P.L.109-432) extends the provision through 2007. MMA also raised the adjustments in Alaska for the work component, practice expense component, and malpractice component to 1.67 for the 2004-2005 period; this provision was not extended.

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[40] U.S. Congress, House Committee on the Budget, *Omnibus Budget Reconciliation Act of 1989*, report to accompany H.R. 3299, Sept. 20, 1989.

Calculation[41]

Work Component. The law defines the physician work component as the portion of resources used in furnishing the service that reflects physician time and intensity. The geographic adjustment to the work component is measured by net income. The data source used for making the geographic adjustment has remained relatively unchanged since the fee schedule began in 1992. The original methodology used median hourly earnings, based on a 20% sample of 1980 census data of workers in six specialty occupation categories with five or more years of college. (At the time, the 1980 census data were the latest available.) The specialty categories were (1) engineers, surveyors, and architects; (2) natural scientists and mathematicians; (3) teachers, counselors, and librarians; (4) social scientists, social workers, and lawyers; (5) registered nurses and pharmacists; and (6) writers, artists, and editors. Adjustments were made to produce a standard occupational mix in each area. HHS has noted that the actual reported earnings of physicians were not used to adjust geographical differences in fees, because these fees in large part are the determinants of earnings. HHS further stated that they believed that the earnings of physicians will vary among areas to the same degree that the earnings of other professionals will vary.

Calculations for the 1995-1997 indices also used a 20% census sample of median hourly earnings for the same six categories of professional specialty occupations. However, the 1990 census no longer used a sample of earnings for persons with five or more years of college. For 1990, data were available for all — education and advanced degree samples. HHS selected the all education sample because it felt the larger sample size made it more stable and accurate in the less populous areas. The 1995-1997 indices also replaced metropolitan-wide earnings with county-specific earnings for consolidated metropolitan statistical areas (CMSAs) which are the largest metropolitan statistical areas.

Virtually no changes were made in the 1998-2000 work indices from the indices in effect for 1995-1997. Similarly, virtually no changes were made in the 2001-2003 work indices.[42] This was because new census data were not available. HHS examined using other sources (including the hospital wage index used for the hospital prospective payment system); however, for a variety of reasons, it was unable to find one that was acceptable. It felt that making no changes was preferable to making unacceptable changes based on inaccurate data. It further noted that updating from the 1980 to 1990 census (for the 1995-1997 indices) had generally resulted in a small magnitude of changes in payments.

It was expected that the 2004 update would reflect the 2000 census data. However, CMS stated that the work and practice expense adjustments relied on

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[41] Much of the discussion in this section is drawn from (1) "Medicare Program; Revisions to Payment Polices Under the Physician Fee Schedule for Calendar Year 2001; Proposed Rule," 65 *Federal Register* 44189, July 17, 2000; and (2) "Medicare Program; Revisions to Payment Polices Under the Physician Fee Schedule for Calendar Year 2001; Final Rule," 65 *Federal Register* 65404, Nov. 1, 2000.

[42] In both cases very slight, very technical adjustments were made.

special tabulations which had not been completed in time for use in the 2004 fee schedule. The 2000 data is being used for 2005-2007. The same data sources and methodology used for the development of the 2001-2003 period were used for the subsequent period.

Practice Expense Component. The geographic adjustment to the practice expense component is calculated by measuring variations for three categories: employee wages, office rents, and miscellaneous.

Employee wages are measured using median hourly wages of clerical workers, registered nurses, licensed practical nurses, and health technicians. As is the case for calculating the work indices, the 2000 census is used for 2005-2007.

Office rents are measured by using residential fair market rental (FMR) data for residential rents produced annually by the Department of Housing and Urban Development (HUD). Commercial rent data has not been used because HHS has been unable to find data on commercial rents across all fee schedule areas. HUD publishes the data on a metropolitan area basis. The 2005-2007 indices are based on FY2004 FMR data.

The costs of medical equipment, supplies, and miscellaneous expenses are assumed not to vary much throughout the country. Therefore, this category has always been assigned the national value of 1.000.

Malpractice component. Malpractice premiums are used for calculating the geographic indices. Premiums are for a mature "claims made" policy (a policy that covers malpractice claims made during the covered period) providing $1 million to $3 million coverage. Adjustments are made to incorporate costs of mandatory patient compensation funds. Initially, premium data were collected for three risk classes: low risk (general practitioners), moderate risk (general surgeons), and high risk (orthopedic surgeons). Subsequently data was collected on more specialties and from more insurers. An average of three-years of data is used to smooth out year-to-year fluctuations. Premiums data for 1996-1998 was used for the 2001-2003 indices.

Only the geographic index for malpractice was adjusted for 2004. Half of the change was implemented in 2004; the other half was implemented in 2005. CMS indicates that it may make additional changes upon receipt of more recent data.

Appendix C. Development of Practice Expense Payment Methodology

Practice Expenses

Background. The relative value for a service is the sum of three components: physician work, practice expenses, and malpractice expenses. Practice expenses include both direct costs (such as nurses and other nonphysician personnel time and medical supplies used to provide a specific service to an individual patient) and indirect costs (such as rent, utilities, and business costs associated with maintaining a physician practice). When the fee schedule was first implemented in 1992, the calculation of work relative value units was based on resource costs. At the time, there was insufficient information to determine resource costs associated with practice expenses (and malpractice costs). Therefore payment for these items continued to be based on historical charges.

A number of observers felt that the use of historical charges provided an inaccurate measure of actual resources used. The Social Security Act Amendments of 1994 (P.L. 103-432) required the Secretary of Health and Human Services to develop a methodology for a resource-based system which would be implemented in CY1998. HCFA (now CMS) developed a proposed methodology which was published as proposed rule-making June 18, 1997. Under the proposal, expert panels would estimate the actual direct costs (such as equipment and supplies) by procedure; HCFA then assigned indirect expenses (such as office rent and supplies) to each procedure. This "bottom up" methodology proved quite controversial. A number of observers suggested that sufficient accurate data had not been collected. They also cited the potential large scale payment reductions that might result for some physician specialties, particularly surgical specialties.

BBA 97. BBA 97 delayed implementation of the practice expense methodology while a new methodology was developed and refined. BBA 97 provided that only interim payment adjustments to existing historical charge-based practice expenses would be made in 1998. It established a process for the development of new relative values for practice expenses and provided that the new resource-based system would be phased-in beginning in CY1999. In 1999, 75% of the payment would be based on the 1998 charge-based relative value unit and 25% on the resource-based relative value. In 2000, the percentages would be 50% charge-based and 50% resource-based. For 2001, the percentages would be 25% charge-based and 75% resource-based. Beginning in 2002, the values would be totally resource-based.

HCFA developed the required new methodology which was labeled the "top down" approach. For each medical specialty, HCFA estimated aggregate spending for six categories of direct and indirect practice expenses using the American Medical Association's (AMA's) Socioeconomic Monitoring System (SMS) survey data and Medicare claims data. Each of the direct expense totals (for clinical labor, medical equipment, and medical supplies) were allocated to individual procedures based on estimates from the specialty's clinical practice expert panels (CPEPs). Indirect costs (for office expenses, administrative labor, and other expenses) are

allocated to procedures based on a combination of the procedure's work relative value units and the direct practice expense estimates. If the procedure was performed by more than one specialty, a weighted average was computed; this average was based on the frequency with which each specialty performed the procedure on Medicare patients. The final step was a budget neutrality adjustment to assure that aggregate Medicare expenses were no more or less than they would be if the system had not been implemented.

Subsequent Modifications. During the phase-in period, Congress and others continued to evidence concern regarding the survey data being used. BBRA 99 required the Secretary to establish a process under which data collected or developed outside HHS would be accepted and used to the maximum extent practicable and consistent with sound data practices. These outside data would supplement data normally developed by HHS for determining the practice expense component. Under this authority, CMS has accepted supplemental data from seven specialties.

CMS continued to refine practice expense relative value units on an ongoing basis. Assisting in this process was a multispecialty subcommittee of the AMA's RUC. This subcommittee, the Practice Expense Advisory Committee (PEAC), reviewed CPEP clinical staff, equipment, and supply data for physicians' services. It made recommendations to CMS based on this review. CMS implemented most of the refinements recommended by the RUC and PEAC. Recently, the PEAC was replaced by the Practice Expense Review Committee (PERC).

In its proposed rule-making for the 2006 fee schedule, CMS proposed to revise the calculation used to determine practice expenses. This proposal was withdrawn in the final rule, primarily because incorrect calculations were published in the proposed fee schedule. A modified version is incorporated in the 2007 fee schedule.

2007 Fee Schedule. The 2007 fee schedule incorporates a major revision in the way practice expenses are calculated. CMS states that the revisions should make the process more transparent and easier to understand. The following are the major changes:

- Use of a "bottom-up" method to calculate direct practice expenses. CMS states that data refinements by the PEAC/PERC/RUC process has enabled it to use this approach. The direct costs are to be determined by adding the costs of the resources (clinical staff, equipment and supplies) typically required to provide the service.

- Use of practice expense survey data from eight specialties: allergy/immunology, cardiology, dermatology, gastroenterology, radiology, radiation oncology, urology and independent diagnostic testing facilities.

- Elimination of an exception to the previous methodology, the "nonphysician work pool" which was used to calculate practice expenses for service codes without a physician work component (i.e. technical component codes and codes for services furnished by

nonphysicians). These services will now be priced using the standard practice expense methodology.

- Incorporate technical modifications in the calculation of indirect practice expenses.

The changes are to be phased-in over four years, 2007 -2010.

Appendix D. Private Contracting Rules

Private Contracting

Private contracting is the term used to describe situations where a physician and a patient agree not to submit a claim for a service *which would otherwise be covered and paid for by Medicare*. Under private contracting, physicians can bill patients at their discretion without being subject to upper payment limits specified by Medicare. HCFA (now CMS) had interpreted Medicare law to preclude such private contracts. BBA 97 included language permitting a limited opportunity for private contracting, effective January 1, 1998. However, if and when a physician decides to enter a private contract with a Medicare patient, that physician must agree to forego any reimbursement by Medicare for all Medicare beneficiaries for two years. The patient is not subject to the two-year limit; the patient would continue to be able to see other physicians who were not private contracting physicians and have Medicare pay for the services.

How Private Contracting Works. HCFA issued regulations November 2, 1998 (as part of the 1999 physician fee schedule regulations) which clarified private contracting requirements. The following highlights the major features of private contracting arrangements.

- *Physicians and Practitioners*. A private contract may be entered into by a physician or practitioner. Physicians are doctors of medicine and osteopathy. (BBA 97 did not include chiropractors, podiatrists, dentists, and optometrists. MMA includes these limited license practitioners, except for chiropractors who remain unable to enter into private contracts). Practitioners are physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, certified nurse midwives, clinical psychologists, and clinical social workers.
- *Beneficiaries*. Private contracting rules apply only to persons who have Medicare Part B.
- *Contract Terms*. The contract between a physician and a patient must: (1) be in writing and be signed by the beneficiary or the beneficiary's legal representative in advance of the first service furnished under the arrangement; (2) indicate if the physician or practitioner has been excluded from participation from Medicare under the sanctions provisions; (3) indicate that by signing the contract the beneficiary agrees not to submit a Medicare claim; acknowledges that Medigap plans do not, and that other supplemental insurance plans may choose not to, make payment for services furnished under the contract; agrees to be responsible for payments for services; acknowledges that no Medicare reimbursement will be provided; and acknowledges that the physician or practitioner is not limited in the amount he or she can bill for services; and (4) state that the beneficiary has the right to obtain Medicare-covered items and services from physicians and practitioners who have not opted-out and that the beneficiary is not

compelled to enter into private contracts that apply to other services provided by physicians and practitioners who have not opted-out. A contract cannot be signed when the beneficiary is facing an emergency or urgent health care situation.

- *Affidavit*. A physician entering into a private contract with a beneficiary must file an affidavit with the Medicare carrier within 10 days after the first contract is entered into. The affidavit must: (1) provide that the physician or practitioner will not submit any claim to Medicare for two years; (2) provide that the physician or practitioner will not receive any Medicare payment for any services provided to Medicare beneficiaries either directly *or on a capitated basis under Medicare Advantage*; (3) acknowledge that during the opt-out period services are not covered under Medicare and no Medicare payment may be made to any entity for his or her services; (4) identify the physician or practitioner (so that the carrier will not make inappropriate payments during the opt out period); (5) be filed with all carriers who have jurisdiction over claims which would otherwise be filed with Medicare; (6) acknowledge that the physician understands that a beneficiary (who has not entered a private contract) who requires emergency or urgent care services may not be asked to sign a private contract prior to the furnishing of those services; and (7) be in writing and be signed by the practitioner.
- *Effect on Non-Covered Services*. A private contract is unnecessary and private contracting rules do not apply for non-covered services. Examples of non-covered services include cosmetic surgery and routine physical exams.
- *Services Not Covered in Individual Case*. A physician or practitioner may furnish a service that Medicare may cover under some circumstances but which the physician or practitioner anticipates would not be considered "reasonable and necessary" in the particular case (for example, multiple visits to a nursing home). If the beneficiary receives an *Advance Beneficiary Notice" (ABN)* that the service may not be covered, a private contract is not necessary to bill the patient if the claim is subsequently denied by Medicare. There are no limits on what may be charged for the non-covered service.
- *Medicare Advantage and Private Contracting*. A private contracting physician may not receive payments from a Medicare Advantage *(formerly Medicare+Choice)* organization for Medicare-covered services provided to plan enrollees under a capitation arrangement.
- *Ordering of Services*. Medicare will pay for services by one physician which has been ordered by a physician who has entered a private contract (unless such physician is excluded under the sanctions provisions). The physician who has opted out may not be paid directly or indirectly for the ordered services.
- *Timing of Opt-Out*. Participating physicians can enter a private contract, i.e., "opt out," at the beginning of any calendar quarter, provided the affidavit is submitted at least 30 days before the

beginning of the selected calendar quarter. Nonparticipating physicians can opt out at any time.

- *Early Termination of Opt-Out.* A physician or practitioner can terminate an opt-out agreement within 90 days of the effective date of the first opt out affidavit. To properly terminate an opt-out, the individual must: (a) notify all carriers with which he or she has filed an affidavit within 90 days of the effective date of the opt-out period; (b) refund any amounts collected in excess of the limiting charge (in the case of physicians) or the deductible and coinsurance (in the case of practitioners); (c) inform patients of their right to have their claims filed with Medicare for services furnished during the period when the opt-out was in effect.

Issues. Prior to passage of the BBA provision, HCFA had interpreted Medicare law to preclude private contracts. Proponents of private contracting argued that private contracting is a basic freedom associated with private consumption decisions. Patients should be allowed to get services from Medicare and not have Medicare billed for the service. Advocates of private contracting generally object to Medicare's payment levels and balance billing limitations. They state that if Medicare is not paying the bill, physicians who choose to private contract should not be governed by Medicare's rules.

Opponents of private contracting contend that the ability to enter into private contracts benefits the pocketbooks of physicians and creates a "two-tiered system" — one for the wealthy and one for other Medicare eligibles. The two-tiered system would allow wealthier beneficiaries to seek care outside of Medicare and could conceivably create a situation where only wealthier beneficiaries have access to the Nation's, or an area's, leading specialists for a medical condition. A further concern is that beneficiaries living in areas served by only private contracting specialists would be unable to afford the bill (which could be any amount) and therefore forgo needed care.

The BBA 97 provision provided a limited opportunity for private contracting. However, the two-year exclusion proved very controversial. Proponents of private contracting viewed the two-year exclusion as a disincentive to enter these arrangements. They argued that physicians should not be excluded entirely from Medicare because of their decision to contract in an individual case. Other observers were concerned that removal of the two-year limit would place beneficiaries at risk. They contended that more physicians would elect to private contract if they could do it on a service-by-service basis. Beneficiaries might not know sufficiently in advance whether a particular service would or would not be paid by Medicare. Following enactment of the private contracting provision in 1997, some efforts were made to eliminate the two-year exclusion. However, the provision has not been amended or repealed, except for the MMA provision allowing podiatrists, dentists, and optometrists to private contract.